FEHB

Federal Employees
Health Benefits Program

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF RETIREMENT PROGRAMS

Claim Number:

Health Benefits Cancellation/Suspension Confirmation

You asked us to suspend or cancel your enrollment in the Federal Employees Health Benefits Program (FEHBP). Because many annuitants who cancel their FEHBP enrollments may never be eligible to reenroll, we want to be sure that you are fully informed about the effect of any action you take. We will not process your request until you sign, date, and return this form indicating that you understand how your request will effect your future FEHBP enrollment eligibility.

Civil Service Retirement System and Federal Employees Retirement System annuitants and benefit recipients may suspend or cancel their FEHBP coverage. The various circumstances surrounding the suspension or cancellation will determine your future reenrollment eligibility. Please read this entire form before checking the **one** block below that describes your situation. Read the information beside the checked block carefully to be sure you understand the effect of your decision.

A. ☐ **I am cancelling my FEHBP enrollment to be covered under a family member's FEHBP enrollment.**

If you are cancelling your FEHBP enrollment because you will be covered under your spouse's FEHBP enrollment and your spouse is a Federal employee, please include with this form a copy of your spouse's SF 2809, *Health Benefits Election Form,* showing the change to a family enrollment. If your spouse is an annuitant, please give us your spouse's name and annuity claim number:

Spouse's name *(Last, first, middle)*	Spouse's claim number

If you cancel FEHBP coverage for this reason, we will coordinate the effective date with the effective date of your new coverage under your spouse's enrollment.

Reenrollment eligibility: As long as you are covered as a family member on your spouse's FEHBP enrollment, you will be eligible to resume your own enrollment if your coverage under your spouse's enrollment ends for any reason.

B. ☐ **I am cancelling my FEHB coverage for reasons other than the situation described in part A.**

If we receive this form (signed and dated) within 31 days after the date at the top of this form, we will cancel your enrollment effective December 31, 2001. Any health benefits premiums you pay for a period after the cancellation effective date will be refunded in one of your future monthly annuity payments. If we receive this form (signed and dated) more than 31 days after the date at the top of the form, we will cancel your enrollment effective at the end of the month in which we receive the form.

Reenrollment eligibility: If you check this block to cancel your FEHBP enrollment, you may **never again be eligible** to reenroll in the FEHBP. Additionally, if you cancel your FEHBP enrollment, you and any family members covered by your enrollment will not be entitled to the free 31-day extension of coverage to convert to an individual health benefits contract or to enroll for temporary continuation of coverage.

I certify that I have read and understand the information on cancelling FEHBP coverage. I understand that if I checked block B, I may never again be eligible to reenroll in the FEHBP.

Signature	Daytime Telephone No.*(including area code)*	Date *(mm/dd/yyyy)*

See Reverse Side for Suspension Confirmation

☐ **I am suspending my FEHBP enrollment to be covered under a Medicare sponsored health plan.**

These Medicare-sponsored plans are HMO's or Fee-for-Service plans approved by the Center for Medicare and Medicaid Services (CMS), formally the Health Care Financing Administration (HCFA). To suspend your coverage for this reason (and to protect your eligibility to reenroll), you must give us evidence that you have enrolled (or have applied to enroll and have been accepted) in a Medicare-sponsored plan. Your documentation must show the effective date of your Medicare-sponsored coverage. If we receive this form within 31 days before or 31 days after the effective date of your Medicare-sponsored enrollment, we will suspend your FEHBP coverage at the close of business the day before your Medicare-sponsored coverage begins. Otherwise, we will suspend your FEHBP coverage at the end of the month in which we receive your request.

☐ **I am suspending my FEHBP enrollment to use TRICARE or TRICARE for Life (enrollees over age 65 with Medicare Parts A and B.)** ***Please suspend my FEHBP effective*** _____.

To suspend your FEHBP coverage for this reason (and to protect your eligibility to reenroll), you must give us evidence of your eligibility for TRICARE or TRICARE for Life. To document your eligibility, please send us a copy of your Uniformed Services Identification (I.D.) Card. If you are over age 65, you must also send us a copy of your Medicare card showing enrollment in both Medicare A and B (required for TRICARE for Life). Please tell us below the date you want to suspend your FEHBP to use TRICARE or TRICARE for Life. If we receive this signed form and the eligibility documentation within 31 days before to 31 days after the date you designate, we will suspend your FEHBP coverage on that date. Otherwise, we will suspend your FEHBP coverage at the end of the month in which we receive your documentation.

☐ **I am suspending my FEHBP enrollment because I am eligible for coverage under Medicaid or a similar State-sponsored program of medical assistance for the needy.**

To suspend your FEHBP coverage for this reason (and to protect your eligibility to reenroll), you must give us evidence of your eligibility for Medicaid or a similar state-sponsored program of medical assistance for the needy. You may send us an enrollment card or a copy of a letter of eligibility which shows the effective date of your Medicaid or similar state-sponsored program coverage. If we receive this form within 31 days before or 31 days after the effective date of your Medicaid or similar state-sponsored enrollment, we will suspend your FEHBP coverage at the close of business the day before your Medicaid or state-sponsored coverage begins. Otherwise, we will suspend your FEHBP coverage at the end of the month in which we receive your request.

The following information applies to blocks C, D, and E.

Reenrollment eligibility: You may voluntarily reenroll in the FEHBP during an annual open season. We will send you an open season package each year with instructions on how to reenroll. If you don't want to reenroll, disregard your open season material.

If you involuntarily lose your TRICARE, TRICARE for Life, Medicare-sponsored health plan or Medicaid or a similar state-sponsored plan, you can reenroll in the FEHBP effective the day after your coverage ends. Your request to reenroll must be received at OPM within the period beginning 31 days before and ending 60 days after your coverage ends. Otherwise, you must wait until open season to reenroll.

I certify that I have read and understand the information on suspending FEHBP coverage. I have checked the block relating to my suspension, and I have enclosed the appropriate documentation.

Signature	Daytime Telephone Number *(including area code)*	Date *(mm/dd/yyyy)*